House of Representatives

File No. 686

General Assembly

February Session, 2014

(Reprint of File No. 627)

Substitute House Bill No. 5440
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 25, 2014

AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT PHYSICIANS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-239 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) (1) Until the time subdivision (2) of this subsection is effective, the rate to be paid by the state to hospitals receiving appropriations granted by the General Assembly and to freestanding chronic disease hospitals providing services to persons aided or cared for by the state for routine services furnished to state patients, shall be based upon reasonable cost to such hospital, or the charge to the general public for ward services or the lowest charge for semiprivate services if the hospital has no ward facilities, imposed by such hospital, whichever is lowest, except to the extent, if any, that the commissioner determines that a greater amount is appropriate in the case of hospitals serving a disproportionate share of indigent patients. Such rate shall be

promulgated annually by the Commissioner of Social Services.

(2) On or after July 1, 2013, Medicaid rates paid to acute care and children's hospitals shall be based on diagnosis–related groups established and periodically rebased by the Commissioner of Social Services, provided the Department of Social Services completes a fiscal analysis of the impact of such rate payment system on each hospital. The Commissioner of Social Services shall, in accordance with the provisions of section 11-4a, file a report on the results of the fiscal analysis not later than six months after implementing the rate payment system with the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. The Commissioner of Social Services shall annually determine in-patient rates for each hospital by multiplying diagnostic-related group relative weights by a base rate. Within available appropriations, the commissioner may, in his or her discretion, make additional payments to hospitals based on criteria to be determined by the commissioner. Nothing contained in this section shall authorize Medicaid payment by the state to any such hospital in excess of the charges made by such hospital for comparable services to the general public.

(b) Effective October 1, 1991, the rate to be paid by the state for the cost of special services rendered by such hospitals shall be established annually by the commissioner for each such hospital based on the reasonable cost to each hospital of such services furnished to state patients. Nothing contained in this subsection shall authorize a payment by the state for such services to any such hospital in excess of the charges made by such hospital for comparable services to the general public.

(c) The term "reasonable cost" as used in this section means the cost of care furnished such patients by an efficient and economically operated facility, computed in accordance with accepted principles of hospital cost reimbursement. The commissioner may adjust the rate of payment established under the provisions of this section for the year

during which services are furnished to reflect fluctuations in hospital costs. Such adjustment may be made prospectively to cover anticipated fluctuations or may be made retroactive to any date subsequent to the date of the initial rate determination for such year or in such other manner as may be determined by the commissioner. In determining "reasonable cost" the commissioner may give due consideration to allowances for fully or partially unpaid bills, reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators, requirements for working capital and cost of development of new services, including additions to and replacement of facilities and equipment. The commissioner shall not give consideration to amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit the commissioner from considering amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations.

(d) (1) Until such time as subdivision (2) of this subsection is effective, the state shall also pay to such hospitals for each outpatient clinic and emergency room visit a reasonable rate to be established annually by the commissioner for each hospital, such rate to be determined by the reasonable cost of such services.

(2) On or after July 1, 2013, hospitals shall be paid for outpatient and emergency room episodes of care based on prospective rates established by the commissioner in accordance with the Medicare Ambulatory Payment Classification system in conjunction with a state conversion factor, provided the Department of Social Services completes a fiscal analysis of the impact of such rate payment system on each hospital. The Commissioner of Social Services shall, in accordance with the provisions of section 11-4a, file a report on the

results of the fiscal analysis not later than six months after implementing the rate payment system with the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. The Medicare Ambulatory Payment Classification system shall be modified to provide payment for services not generally covered by Medicare, including, but not limited to, pediatric, obstetric, neonatal and perinatal services. Nothing contained in this subsection shall authorize a payment by the state for such episodes of care to any hospital in excess of the charges made by such hospital for comparable services to the general public. Those outpatient hospital services that do not have an established Medicare Ambulatory Payment Classification code shall be paid on the basis of a ratio of cost to charges, or the fixed fee in effect as of January 1, 2013. The Commissioner of Social Services shall establish a fee schedule for outpatient hospital services to be effective on and after January 1, 1995, and may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to hospitals in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality.

(e) On and after January 1, 2015, and concurrent with the implementation of the diagnosis-related group methodology of payment to hospitals, an emergency department physician may enroll separately as a Medicaid provider and qualify for direct reimbursement for professional services provided in the emergency department of a hospital to a Medicaid recipient, including services provided on the same day the Medicaid recipient is admitted to the hospital. The commissioner shall pay to any such emergency department physician the Medicaid rate for physicians in accordance with the physician fee schedule in effect at that time. If the commissioner determines that payment to an emergency department physician pursuant to this subsection results in an additional cost to the state, the commissioner shall adjust such rate in consultation with

the Connecticut Hospital Association and the Connecticut College of Emergency Physicians to ensure budget neutrality.

[(e)**]** (f) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing criteria for defining emergency and nonemergency visits to hospital emergency rooms. All nonemergency visits to hospital emergency rooms shall be paid at the hospital's outpatient clinic services rate. Nothing contained in this subsection or the regulations adopted under this section shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public. To the extent permitted by federal law, the Commissioner of Social Services shall impose cost-sharing requirements under the medical assistance program for nonemergency use of hospital emergency room services.

[(f)**]** (g) On and after July 1, 1995, no payment shall be made by the state to an acute care general hospital for the inpatient care of a patient who no longer requires acute care and is eligible for Medicare unless the hospital does not obtain reimbursement from Medicare for that stay.

[(g)**]** (h) The commissioner shall establish rates to be paid to freestanding chronic disease hospitals.

[(h)**]** (i) The Commissioner of Social Services may implement policies and procedures as necessary to carry out the provisions of this section while in the process of adopting the policies and procedures as regulations, provided notice of intent to adopt the regulations is published in **[**the Connecticut Law Journal**]** accordance with the provisions of section 17b-10 not later than twenty days after the date of implementation.

(j) In the event the commissioner is unable to implement the provisions of subsection (e) of this section by January 1, 2015, the commissioner shall submit written notice, not later than thirty-five days prior to January 1, 2015, to the joint standing committees of the

General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies indicating that the department will not be able to implement such provisions on or before such date. The commissioner shall include in such notice (1) the reasons why the department will not be able to implement such provisions by such date, and (2) the date by which the department will be able to implement such provisions.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2014*	17b-239

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill does not result in a cost to the Department of Social Services (DSS) as the bill requires any rate established for emergency department (ER) physicians to be cost neutral. The bill allows an emergency department physician to enroll as a Medicaid provider and receive direct reimbursement for professional services provided in an ER for a Medicaid client. The bill requires DSS to provide written notice to the General Assembly in the event the DSS is unable to implement the provisions of the bill; this provision does not result in a fiscal impact.

House "A" made the following changes: (1) changed the effective date of the ER physician rate to on or after January 1, 2015, (2) eliminated the requirement that the rate have no impact on rates paid to hospitals, (3) eliminated the January 1, 2013 Medicaid rate for ER services as a basis for the ER physician rate, and (4) added a notice requirement in the event a cost neutral rate is not able to be implemented.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB 5440 (as amended by House "A")*

AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT PHYSICIANS.

SUMMARY:

This bill allows, under certain circumstances, an emergency department physician to (1) enroll separately as a Medicaid provider and (2) qualify for direct reimbursement for professional services he or she provides in a hospital emergency department to a Medicaid recipient. These include services provided on the same day the recipient is admitted to the hospital. These provisions apply on and after January 1, 2015 and concurrent with the Department of Social Services (DSS) implementing a diagnosis-related group (DRG) method of reimbursing hospitals for serving Medicaid recipients.

The bill requires the DSS commissioner to pay these physicians the Medicaid rate for physicians under the physician fee schedule in effect at that time. If the commissioner determines that paying a physician under this provision increases the state's cost, the commissioner must adjust the physician's rates to ensure budget neutrality. The commissioner must do this in consultation with the Connecticut Hospital Association and the Connecticut College of Emergency Physicians.

If the commissioner cannot implement these provisions by January 1, 2015, he must notify the Human Services and Appropriations committees at least 35 days before that date (November 27, 2014) that he cannot do so. The notice must include the reasons why DSS cannot implement the provision by the deadline and the date by which it will be able to do so.

By law, the commissioner may implement policies and procedures regarding Medicaid hospital rates while adopting the policies and procedures as regulations. The bill extends this provision to include the emergency department physician rates. Under current law, to use this provision, the commissioner must publish notice of intent to adopt the regulations in the *Connecticut Law Journal* no later than 20 days after the date of implementation. The bill instead requires DSS to (1) submit the proposed policy electronically to the secretary of the state for online posting, (2) post the policy on its web site, and (3) print notice of intent to adopt the regulation in the *Connecticut Law Journal* no later than 20 days after adopting the policy. The policy is valid until the final regulations go into effect. By law, beginning October 1, 2014, all updates of the DSS policies and procedures manual must be posted on the eRegulations System.

*House Amendment "A" (1) delays implementation of the physician payment provisions from July 1, 2014 to January 1, 2015 and requires that they be implemented concurrently with the DRG payment methodology; (2) adds the reporting requirement if the provisions cannot be implemented by January 1, 2015; (3) modifies the payment rate; and (4) eliminates a provision that barred the adjustment from affecting the rates paid to hospitals.

EFFECTIVE DATE: July 1, 2014

BACKGROUND

Diagnostic-Related Groups (DRGs)

Medicaid rates paid to acute care and children's hospitals must be based on DRGs established and periodically rebased by the DSS commissioner, provided DSS completes a fiscal analysis of the impact of this rate payment system on each hospital (CGS § 17b-239). A DRG is a statistical system of classifying inpatient stays into groups for the purposes of payment.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Change of Reference
Yea 18 Nay 0 (03/11/2014)

Appropriations Committee

Joint Favorable
Yea 49 Nay 0 (04/01/2014)